In operation, the probe **400** can be inserted into a patient, preferably into an anchorable location, such as a collagenous tissue, bone, or vertebral disc. FIG. **36**A illustrates the probe **400** being inserted into a patient (not fully shown) toward the spine (only a first vertebra **440**, second vertebra **450**, and disc **460** are illustrated in this representative example). The probe **400** illustrated in FIG. **36**A is a thin, blade like rectangular probe **400** with a triangular anchor tip **430** and squared corners where the distal shoulders **420** meet the edges of the probe **400**. The structure of the probe **400** can facilitate its passage through tissues of a patient which can run parallel to the flat surfaces of the probe. In operation, a physician can select a location in which he desires to use a retractor **10** to form an operative channel in the tissues of the patient (the spine will be used in this example for illustration purposes only). After the surgeon selects the location for retractor **10** placement, he can insert the probe **400** by placing the anchor tip **430** against the surface of the patient and applying pressure to the proximal end **413**. The physician can then continue to apply pressure, thereby pushing the probe **400** through the tissue of the patient, until the probe **400** is fully in place. In some embodiments, an imaging modality can be used during the insertion of the probe **400**. As a representative, non-limiting example, X-ray fluoroscopy can be used during insertion of the probe **400** to ensure correct placement. Any appropriate imaging modality can be used to monitor the placement of the probe **400**. In some embodiments, a surgeon can make an incision with another instrument, such as a scalpel, prior to the insertion of the probe **400**, into which the probe **400** is inserted.

FIG. **36**B illustrates the probe **400** fully in place in a patient. The probe **400** has been inserted into the side of the spinal column (here defined by a first vertebra **440**, a second vertebra **450**, and the disc **460** between them). FIG. **36**B illustrates the placement of the probe **400** in a location in which the anchor tip **430** can anchor the probe **400**. As shown in FIG. **36**B, the probe **400** has been inserted into the patient until the anchor tip **430** has sunk at least some distance into the disc **460** between the first vertebra **440** and second vertebra **450**. The anchor tip **430** has sunk into the disc **460** up until the distal shoulders **420** of the probe **400**. The distal shoulders **420** serve in this example to limit the possible insertion depth of the anchor time **430** of the probe **400**.

FIG. **36**C illustrates a retractor **10** (as disclosed herein) and a placed probe **400**. The retractor **10** has blades as disclosed above which, when in their close conformation, fit substantially closely around the probe **400**. The blades of the retractor **10** can be any type of blade as described above, including but not limited to a comb style blade, a fan style blade, or a combination style blade.

FIG. **36**D illustrates the retractor **10** and placed probe **400** of FIG. **36**C where the blades of the retractor **10** in their closed conformation have been placed around the probe **400** and slipped down around the probe **400** into the channel already formed by the probe **400** in the patient, to the spine. FIG. **36**D shows the retractor **10** still in its closed conformation and the blades still in their closed conformation such that the blades substantially closely enclose the probe **400**. FIG. **36**E illustrates the same retractor **10** of FIG. **36**D where the retractor **10** has been engaged and the blades have been deployed (both as have been disclosed fully above) to pull open the incision formed by the insertion of the probe **400**.

FIG. **36**F illustrates the retractor **10** and blades in place prepared for physician access to the desired spinal location wherein the probe **400** has been removed for physician access. The probe **400** can allow a surgeon to easily and quickly insert a retractor **10** without cutting an incision all the way to the surgery site prior to inserting the retractor **10** into the desired location to access the surgery site. Rather, the surgeon can quickly and easily insert the probe **400** into the desired location, anchor the probe **400** using the anchor tip **430** in the desired location, slip the blades of the retractor **10** around the probe **400**, and then simply slip the retractor **10** into place at which point in time the retractor and blades can be engaged to open up the surgical site and the probe **400** may be removed.

In one embodiment, the probe **400** comprises at least one electrode, wherein the at least one electrode is capable of stimulating a nerve to provoke an electromyographic response in the nerve. FIG. **37**C illustrates a probe **400** with an electrode **431** disposed at the distal end **412** of the probe **400** on the anchor tip **430**. In some embodiments, only one electrode is used. In other embodiments, a plurality of electrodes can be used, including about 1-10 electrodes, about 2-8 electrodes, about 3-6 electrodes and about 4-5 electrodes. In some embodiments, at least one electrode can be disposed on the anchor tip **430**. In some embodiments, at least one electrode can be disposed on the probe body **410**. The electrod **431** can be allowed to any of the embodiments described hering

In some embodiments, the probe **400** comprises an endoscope **499**, wherein the endoscope **499** can comprise an imaging element **432** at the distal end **412** of the endoscope **499**. In some of these embodiments, the endoscope **499** can be configured to both allow a surgeon to visualize the placement of the probe **400** as well as allow a surgeon to slide a retractor **10** down over the probe **400** and into place as described herein to create an operative channel. In some embodiments, the endoscope **499** can include an anchor tip **430**. Such an endoscope can be applied to any of the embodiments described herein.

While preferred embodiments of the present invention have been shown and described herein, it will be obvious to those skilled in the art that such embodiments are provided by way of example only. Numerous variations, changes, and substitutions will now occur to those skilled in the art without departing from the invention. It should be understood that various alternatives to the embodiments of the invention described herein may be employed in practicing the invention. It is intended that the following claims define the scope of the invention and that methods and structures within the scope of these claims and their equivalents be covered thereby.

What is claimed is:

1. A system for creating an operative corridor in a human body, comprising:

a probe, wherein the probe is configured to be placed through the tissues of a patient from the surface of the tissue to a location of interest;

a retractor system, wherein the retractor system comprises a blade assembly comprising a first blade rotatable about a first axis and a second blade rotatable about said first axis, the first and second blades having an internal space, wherein the internal space is substantially the same shape as the probe such that the internal space will slip over the probe when the probe is inserted into the tissues of the patient;

wherein the retractor system is configured to move the blade assembly in a direction generally perpendicular to the first axis the movement of the blade assembly being independently controllable from the rotation of the first blade and second blade.

2. The system of claim **1**, wherein the probe has a circular cross-section.

3. The system of claim **1**, wherein the probe has a rectangular cross-section.